CC: DR. NOLI CAVA
PINGFENG DU, MD
JAMIESON GLENN, MD
Authenticated by Ardeshir A. Dabestani, M.D. On 09/10/2014 09:30:14 AM

Scripps

PATIENT DISCHARGE / INTERFACILITY TRANSFER INSTRUCTIONS

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Nurse to complete asterisked items (*). Physician to complete shaded areas.

***Discharged to:** ☐ Home ☐ Home with Home Health ☐ Acute Rehab ☐ Assisted Living ☐ Board and Care ☒ SNF
☐ Other: Las Villas de Carlsbad
*Mode of transport: ☒ Auto ☐ Ambulance ☐ Wheelchair Transport ☐ Other

Follow up Appointments
Primary Physician: Dr. Moli Cava Call to be seen in 7 days, Phone: (619) 221-4490
Specialty Doctor Ping Feng Dr Reason Cardiology see in 14-21 days, Phone: (760) 330-6660
Specialty Doctor Jamieson Glenn Reason Ortho spine see in 7-10 days, Phone: (760) 230-5188
Specialty Doctor ____ Reason ____ see in ____ days, Phone: ____
Diet: ☐ Regular ☒ Cardiac ☒ Diabetic ☐ 2gm Sodium ☐ Soft ☐ Other: ____
(Circle) Diet/swallow precautions or instructions: ____

Activity: No restrictions unless noted below
☐ May resume all normal activities in ____ (circle) days / weeks
☐ No shower until ____ ☐ No bath until ____
☐ No lifting more than ____ pounds ☐ Weight bearing restriction: ____
☐ Until further instructed by MD, walk with ☐ Walker ☐ Crutches ☐ Other: ____
Driving: ☐ In ____ days ☐ when cleared by MD **Work:** ☐ In ____ days ☐ when cleared by MD

C. Diff precautions

Labs: ☐ PT/INR in ____ days ☒ **Other labs/procedures:** √ CBC + BMP in 3 days

***Incision Instructions:** Keep wound clean and dry ☐ Okay to leave open to air
*Notify surgeon for fever, chills, increased drainage, redness, and/or pain.

***Wound Care:** Pressure Ulcer Present: ☒ No ☐ Yes Stage/Location: ____
Instructions: ____

***Other Information / Instructions:** * Do NOT Disclose ANY Pt. info, except to Pts Nephew - Ralph Sanders (714) 262-8378
- If discharge back pain, consider TLSO Brace.

***Immunizations given in hospital as applicable:** ☐ Flu ☐ Pneumonia ☐ Date given: (if known) ____

Continuing Care
For: ☐ RN ☐ PT ☐ OT ☐ Speech ☐ Wound ☐ Other: ____
*Agency: ____ *Phone: ____
☐ **Infusion** of: ____ *Agency: ____ *Phone: ____
☐ **Equipment:** ☐ Oxygen at ___ liters/min *Agency: ____ *Phone: ____
Other equipment: ____ *Agency: ____ *Phone: ____

***Information to be completed for next caregiver/SNF**
Report called to: (760) 434-4322
***Care Navigator Name/#** Diane Slayton, RN
☒ SNF Accepting MD Dr. Daniel Given
Time of last meal: ____ Time of last pain medication: ____ ☐ Confused/ forgetful
Foley catheter inserted (date): ____ Incontinent: ☐ stool ☐ urine Last Bowel Movement: ____
Needs assist with: ☐ Bathing/dressing ☐ Eating ☐ Ambulation ☐ Other ____
Advanced Directive: ☐ No ☐ Yes ☐ Copy With Patient
Infection: ☐ MRSA ☐ C. Difficile ☐ VRE ☐ Other ____

PHYSICIAN SIGNATURE	DATE/TIME	PATIENT SIGNATURE	NURSE SIGNATURE	DATE/TIME
	9/6/14 12:35			9/6/14

☐ Belongings sheet reviewed with patient
☐ Discharge instructions/medications reviewed with patient/family and copies given.

2DCIN

PHOTOCOPY ON DISCHARGE

Original: Chart Copy: Patient 320-8720-807 (11/11/13)

FAX 760-720-3194 Attn:

GE

Scripps
(760) 633-6501

SYMPTOMS TO REPORT AND ADDITIONAL RESOURCES/INFORMATION

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1. URGENT SYMPTOMS: CALL 911 IF YOU HAVE ANY OF THE FOLLOWING SUDDEN SYMPTOMS:

Sudden onset of STROKE related symptoms:
- Weakness or numbness of face, arm or leg (especially on 1 side)
- Confusion, trouble talking or understanding
- Change in vision in one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

HEART FAILURE/HEART ATTACK related symptoms:
- New or worsening chest pain/discomfort (especially with one or more of the other signs)
- Discomfort in other areas of upper body (one/both arms, neck, jaw, stomach)
- Shortness of breath
- Cold sweats, nausea, lightheadedness

2. OTHER SYMPTOMS TO REPORT/INCLUDE: Call your doctor to report symptoms before they become urgent.

STROKE:
- Increased fatigue or sudden decrease in ability to do usual activities
- Depression
- Seizures • Bleeding or severe bruising

INFECTION:
- Fever, sweating, chills, muscle, joint or body aches
- Swelling/drainage of surgical site or wound
- Excessive bleeding

CHEST PAIN/HEART FAILURE:
- Worsening chest pain even if relieved by medication
- Weigh yourself daily and report any weight gain >2 pounds in 1 day or 5 pounds in 1 week
- Swelling in feet, legs, hands or abdomen
- Persistent cough or chest congestion, bloody or pink sputum
- Increasing shortness of breath, new shortness of breath when resting, trouble sleeping due to breathing, needing to sleep sitting up or with more pillows
- Fast or irregular heart beats

PAIN: • Increasing or unrelieved pain

CANCER:
- Unusual bleeding or discharge
- A lump or thickening in the breast or otherwise
- A sore that does not heal
- Change in bowel or bladder habits.
- Persistent hoarseness or cough
- Persistent indigestion or difficulty in swallowing
- Change in a wart or mole

3. OTHER INFORMATION

RISK FACTORS FOR STROKE AND HEART DISEASE:
- High blood pressure, smoking, diabetes, high blood cholesterol, atrial fibrillation, overweight, low levels of physical activity, and use of illegal drugs such as cocaine and methamphetamine can be controlled, prevented or treated.
- Getting older, race, family history and medical history (especially of heart disease, stroke or TIA) cannot be changed.

STAYING HEALTHY:
- Take your medications exactly as prescribed.
- Take precautions to avoid falls.
- Maintain a healthy body weight, keep active as tolerated or per your physician orders.
- Always wear your seat belt.
- Use sunscreen every day.
- DO NOT SMOKE. Talk to your doctor, nurse or other healthcare professionals about how to quit.

LOVENOX (Enoxaparin) and/or COUMADIN (Warfarin) EDUCATION:
1. Inform your physician of your health history.
2. Keep your appointments for regular blood tests.
3. Side effects may include bleeding or bruising.
4. Contact your physician immediately if you experience excessive or prolonged bleeding, sudden back pain. Report other symptoms as outlined above.
5. Ask your doctor or pharmacist before using other medications, including over-the-counter medications.
6. Be consistent with your dietary intake of vitamin K rich food (leafy green vegetables).
7. Changes to diet and medication can affect PT/INR level.
8. Do not take or discontinue any medication or over-the-counter medication except on the advice of the physician or pharmacist.
9. Notify physician before changing diet.

DIET: A diet low in fat is recommended to decrease the risk of heart disease, stroke, and certain forms of cancer. If you have high blood pressure or heart failure, eat less sodium or salt.

RESOURCES:
- American Cancer Society: (1-800-227-2345), www.cancer.org
- American Heart Association: 1-800-242-8721, www.americanheart.org
- American Lung Association: (1-800-586-4872), www.lungusa.org
- American Stroke Association: 1-888-478-7653, www.StrokeAssociation.org
- California Smokers' Help Line: 1-800-NO-BUTTS (1-800-662-8887)
- START (a community program of Scripps Encinitas Rehabilitation Center): 1-800-388-7717
- Scripps Whittier Diabetes Program: 1-877-WHITTIER

DETACH AT PERFORATION

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Scripps Encinitas

EMERGENCY RECORD

PATIENT: RIVES , BOBBYE J
MR#: 000200251338 ACCT#: 000102074264
DATE OF SERVICE: 09/01/2014

AGE:
86 years old.

TIME OF EVALUATION:
1830.

MODE OF ARRIVAL:
To the department is ambulatory.

CHIEF COMPLAINT:
Nausea, vomiting, weakness, and abdominal pain.

HISTORICAL SOURCES:
1. The patient.
2. The patient's cousin Beverly, 310-985-1501.
3. The patient's niece who is an OB/GYN physician at Sharp, Rosalyn Baxter, 858-250-5931.

*****This is a critical care note. Total critical care time is 40 minutes excluding the procedures.

Ms. Beverly who lives in Los Angeles called the neighbors and asked them to check on her. There have been some domestic issues at the house, and Adult protective Services are involved. The neighbors went to check on Bobbye; and she was complaining of nausea, vomiting, diarrhea, had not been taking her medications, dehydrated, lightheaded, no fevers, no chills, and just not feeling well. There was some concern about her ability to make decisions and take care of herself. Paramedics picked her up and brought her to Scripps Encinitas as she complains of generalized weakness, vomiting, and somewhat confused. Pain location: All over the abdomen. Quality crampy. Severity, moderate. Duration: One-and-a-half days, constant. Associated with fevers, chills, no hemoptysis, no hematemesis.

PAST MEDICAL HISTORY:
Her past medical history is notable for coronary artery disease, diabetes, congestive heart failure, and multiple cardiac stents.

MEDICATIONS:
1. Plavix.
2. Aspirin.
3. Iron.
4. Nitroglycerin.
5. Protonix.
6. Toprol.
7. Glucotrol.
8. Glucophage.
9. Lotrel.

10. Zetia.

The patient has not been taking her medications.

SOCIAL HISTORY:
No ethanol, tobacco, or drugs.

FAMILY HISTORY:
Positive for mental illness.

REVIEW OF SYSTEMS:
All other systems reviewed; and, otherwise, negative unless stated in the HPI.

PHYSICAL EXAMINATION:
VITAL SIGNS: 192/86, pulse 110, respiratory rate 18, temperature 37, and 98%.
HEENT: Nares clear. Oropharynx clear. Trachea midline, somewhat confused. She is hard of hearing; but if we speak loud in the left ear as opposed to the right, she appears to be able to hear and answer some questions. Supple neck. No meningismus.
HEART: Tachycardic. Point of maximal impulse is not displaced. 1/6 systolic murmur. Mild JVD. Questionable rales at the bases.
LUNGS: Clear. Rales at the bases. No inspiratory stridor. No accessory muscle use. Equal expansion. No flail chest.
GI: Abdomen soft, tender in the left lower quadrant without guarding, rebound, or percussion tenderness. No organomegaly. A little discomfort in right upper quadrant as well; but again no rigidity, no guarding, no rebound, no percussion tenderness, no organomegaly, no pulsatile abdominal mass. There does not appear to be pain out of proportion, 2+ groin pulses.
SKIN: No petechia, no purpura, poor turgor.
MUSCLES: No deformity.
SKIN: As stated above.
NEUROLOGIC: Moving all extremities and nonfocal.
ENDOCRINE: No cushingoid-type features.
PSYCH: Alert to person and place, difficult with time.
LYMPH: No lymphedema.
ALLERGIC: No allergic reaction.

EMERGENCY ROOM COURSE:

The patient really appears to have some metabolic issues, concerns for hyperosmolar nonketotic coma, sepsis, urinary tract infection, myocardial infarction, anemia, and pancreatitis prompted an extensive workup here in the department.

******My interpretation of the patient's EKG; sinus tachycardia, ventricular rate 114, PR 134, QRS 112, QTc 479, left axis deviation, intermittent, no evidence of ST-segment elevation. This is an abnormal EKG without acute evidence of ischemia.

*****One-view chest x-ray, no infiltrate, no effusion, no pneumothorax. Normal one-view chest x-ray.

CT abdomen and pelvis: No acute process, diverticula, no evidence of diverticulitis, compression fracture at L2, retropulsion, 50% height loss, chronic T9 compression fracture,

6E

abnormal.

Ultrasound: Normal gallbladder, no evidence to explain the patient's bump in LFTs.

Interpretation of the blood work: Urinalysis 3 to 5 whites, no bacteria, abnormal urinalysis. Micro; elevated glucose with ketones, abnormal CBC. White count 23,000 elevated with a left shift and anemia. Etiology of this could be related to regional bowel wall ischemia, DKA, hyperosmolar coma. This is an abnormal finding concerning for systemic inflammatory response system and sepsis.

Beta-hydroxybutyrate is elevated at 19, abnormal. INR 1, no coagulopathy. CPK-MB is normal. Lactic acid 2.8, lactic acidosis. CK 102, no rhabdo, mag 2.3. BNP of 3000 and congestive heart failure. This is abnormal, probable high output heart failure. Comprehensive metabolic panel: Bicarb is 20, glucose 238, abnormal comprehensive metabolic panel, creatinine 1.6, elevated LFTs which is abnormal, troponin 0.031 concerning for enzyme leak, respiratory alkalosis. This is concerning ABG and abnormal.

The patient was bolused with 500 mL of normal saline, in and out cath failed to show urine. She was covered empirically with Rocephin and Flagyl.

The case was discussed with Dr. Pingfeng Du in Cardiology, agrees with the management plan. Admission to the PCU. Given the patient's mental status, I have discussed the case with the family. She is full code and full care.

IMPRESSION:

1. Sepsis.
2. Hyperosmolar nonketotic state.
3. Alkalosis.
4. Abdominal pain concerning for bowel ischemia, improving with intravenous fluids at this point.
5. Nausea, vomiting, and diarrhea. No history of Clostridium difficile colitis. No recent antibiotics.
6. Global weakness.
7. Dehydration.
8. Diabetes with hyperglycemia.
9. Nausea and vomiting.

On repeat assessment, the patient is resting comfortably at this point in time, pulse is 90, 180/70. Pain is controlled. Her mental status appears to be improving with hydration and metabolic management. Plan will be admit to the PCU. Code status, full code. The patient is guarded at this time.

*****This is a critical care note. Total critical care time is 40 minutes excluding the procedures.

DICTATED BY: ANDREW ACCARDI, MD

AA:Spheris77732 C: 09/02/14 01:16 CONFIRMATION #: 521484
D: 09/01/14 22:10 T: 09/02/14 01:16 DOCUMENT: 201409020990073600

CC: PINGFENG DU, MD
DR. ROSALYN BAXTER
Authenticated and Edited by Andrew J. Accardi, M.D. On 9/03/14 10:44:31 PM

Scripps

EMERGENCY/URGENT CARE CENTER
DEPARTMENT NURSING FLOWSHEET

RIVES, BOBBYE J
MRN:200251338 DOB:10/23/1927 F/86
09/01/14 ED ACCT: 102074264
MACCORMICK, RONALD JAMES
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Chief complaint: generalized weakness
N/V, denies pain

☒ Ambulance ☐ Helo ☐ Walk-in To Intake Bed Time: _____
Priority: ☐ 1 ☐ 2 ☐ 4
Screening RN _____ **Date** 09/01/14
Block Print 181316 **Time** 18:45
☐ LWOT Time _____

☐ **Pediatric:** ☐ Good eye contact ☐ Active ☐ Playful ☐ Quiet ☐ Lethargic ☐ Strong Cry ☐ Consolable ☐ Inconsolable ☐ Weak cry
☐ 2012 Child passenger safety instructions reviewed

9) Pain Location: denies

Provoked	
Quality	
Radiates	
Severity	
Time or Treatment	

☐ NRS ☐ VDS ☐ CNPI ☐ FPS-R ☐ FLACC ☐ NIPS

1) Effective Breathing and Gas Exchange evidenced by
- Unlabored respiratory effort
- No report of symptoms or distress
- RR appropriate for age
- Absence of restlessness, anxiety, or confusion.

☒ **Goal Met**

☐ **Goal Not Met** _____
☐ Stridor ☐ Cough
☐ Drooling ☐ Productive:
☐ Obstruction Color _____
Dyspnea:
☐ mild ☐ moderate ☐ tripoding
☐ accessory muscle use
☐ substernal retractions

Lungs	RU	LU	RL	LL
Clear				
Wheezes				
Rales				
Rhonchi				
Diminished				
Absent				

☐ home O2 ___ L Smokes: yes ☐ no ☐

Intubation: PTA ☐
Time _____
Size: ____ Rate ____
TV ____
FIO2 ____ PEEP ____
Depth ____ cm teeth
CO2 color change ☐
Bilat lung sounds ☐
Trachea Midline ☐

2) Effective Cardiac Output and Tissue Perfusion evidenced by:
- Adequate HR and B/P
- Cardiac rhythm Regular
- No report of symptoms or distress
- Warm and dry skin
- Appropriate color for ethnicity

☒ **Goal Met**

☐ **Goal Not Met** weak/tired
☐ **Monitored** ☐ **Alarms Reviewed**
Cardiac Rhythm: _____
☐ **CODE STEMI**

Skin: ☐ Pale ☐ Ashen ☐ Cool ☐ Clammy ☐ Diaphoretic
Edema: ☐ None ☐ Non-pitting ☐ Pitting Location: _____

Pulses	R	L
Radial		
Femoral		
Pedal		
Brachial		

0-none 1- weak 2-strong

3) Optimal Neurological function as evidenced by:
- Alert and cooperative
- Oriented to person, place, time & circumstance
- Ability to follow instructions
- Clear speech
- Absence of aspiration risk
- No report of symptoms or distress

☒ **Goal Met**

☐ **Goal not met:** _____
☐ **CODE STROKE (SEE NIHSS ASSESSMENT)** _____ ☐ **See neuro flow sheet** ☐ **Baseline**

Aspiration risk:
(Required for All ALOC/STROKE)
☐ Coughing or frequent throat clearing
☐ "Wet Sounding or hoarse" voice
☐ Slurred speech
☐ Weak ineffective cough
☐ Inability to handle secretions
☐ **None present**
☐ **NPO Initiated**

	RT	LT
Pupils		
UE		
LE		

+ reactive – nonreactive
0-none 1-weak 2-strong

Glasgow Coma Score
Eye ____
Verbal ____
Motor ____
Total ____

☐ Headache
☐ Blurred vision
☐ Double vision
☐ Photophobia
☐ Dizziness
☐ Neck or back pain
☐ Numbness
Location _____

4) Effective Gastrointestinal function evidenced by
- No symptoms or complaint
- If obtained,
  - o bowel sounds present
  - o Abd. soft, non-tender

☐ **Goal Met**

☒ **Goal not met:** denies pain
☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Bloody or Black stool
☐ Coffee ground/Hematemesis
Bowel sounds: ☐ Last BM: _____
☐ hypoactive ☐ Last meal: _____
☐ hyperactive Device: _____

5) Optimal Genitourinary/ Gynecological function as evidenced by:
- No report of symptoms
- Knows pregnancy or lactation
- Absence of discharge
- If obtained, clear yellow urine

☒ **Goal Met**

☐ **Goal not met:** _____
☐ Dysuria ☐ Frequency ☐ Hematuria
☐ Oliguria ☐ Dialysis ☐ Incontinent
☐ Unable to void ___ Hrs.
Device _____
☐ Discharge _____
☐ Vag.Bleed Pads/hr _____
☐ Gravida ____ ☐ Para _____

6) Effective Endocrine function and **Hematologic** status maintained as evidenced by
- No history of diabetes
- No symptoms of hypoglycemia
- No symptoms of hyperglycemia
- No signs or symptoms of bleed
- Pink skin

☒ **Goal Met**

☐ **Goal not met:** _____
☐ DM Type I II ☐ Hx of anemia
☐ polyuria Type _____
☐ polyphagia ☐ Palor
☐ polydypsia ☐ weakness
FSBS Time: _____
☐ oral med ☐ Insulin
☐ Epistaxis
☐ at risk for bleeding due to meds

7) Effective Nutrition and Hydration as evidenced by:
- No report of symptoms
- Appearance of wellbeing
- Participates in tx plan

☒ **Goal Met**

☐ **Goal not met** _____
☐ Poor skin turgor
☐ Unexplained wt loss or gain
☐ Underweight
☐ Other _____

RN: _____ **Date:** 09/01/14
Printed Name/Corp ID: 181316 **Time:** _____

4ED

100-7010-7727SW (Rev. 5/6/13)

GE

Glasgow Coma Scale

Glasgow Coma Scale	Adult/Child	Score	Infant
Eye Opening	Spontaneous	4	Spontaneous
	To verbal	3	To verbal
	To pain	2	To pain
	No response	1	No response
Best Verbal response	Oriented	5	Coos, babbles
	Disoriented	4	Irritable cry
	Inappropriate words	3	Cries only to pain
	Incomprehensible sounds	2	Moans to pain
	No response	1	No response
Best Motor response	Obeys commands	6	Spontaneous
	Localizes pain	5	Withdraws from touch
	Withdraws from pain	4	Withdraws from pain
	Abnormal flexion (decorticate)	3	Abnormal flexion (decorticate)
	Abnormal extension (decerebrate)	2	Abnormal extension (decerebrate)
	No response	1	No response

PAIN ASSESSMENT TOOLS:

NRS - Numerical Rating Scale
VDS - Verbal Descriptor Scale
FPS-R - Faces Pain Scale-Revised
CNPI - Nonverbal pain indicators
FLACC - Face, Legs, Activity, Cry, Consolability (2 mo-7 yrs)
NIPS - Neonatal-Infant Pain Scale (0-12 mo)

SEDATION SCALES (Select scale for desired patient outcome)

Prevent Sedation: POSS

S - Sleep, easy to arouse
1 - Awake and alert
2 - Slightly drowsy, easily aroused
3 - Frequently drowsy, arousable, drifts off to sleep during conversation
4 - Somnolent, minimal or no response to physical stimulation

Goal Directed Sedation: RASS

+4 - Combative violent danger to self or others
+3 - Very agitated, pulls tubes, aggressive
+2 - Agitated nonpurposeful movement fight ventilator
+1 - Restless anxious movement not aggressive
0 - Alert and calm
–1 - Eyes open to voice, eye contact > 10 sec
–2 - Eyes open to voice, eye contact < 10 sec
–3 - Any movement to voice, no eye contact
–4 - Any movement to physical stimulation, not to voice
–5 - Unarousable to voice or physical stimulation

Procedural Sedation: MRS

1 - Anxious and agitated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to nailbed pressure, loud auditory stimulus
5 - Sluggish response to nailbed pressure, loud auditory stimulus
6 - No response to nailbed pressure or loud auditory stimulus

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EMERGENCY/URGENT CARE CENTER DEPARTMENT NURSING FLOWSHEET

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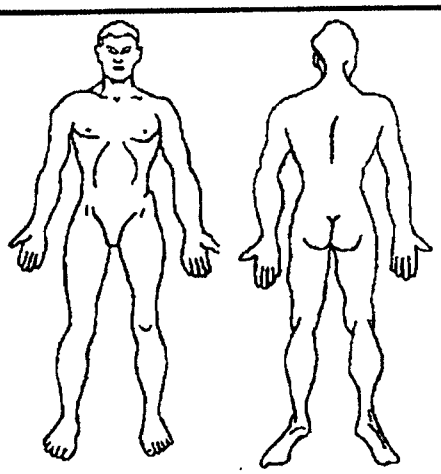
MRN:200251338 DOB:10/23/1927
09/01/14 ED ACCT: 102074264
MACCORMICK, RONALD JAMES
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS
Date of SERVICE: _____

8) Maintain baseline **Skin Integrity** as evidenced by no report of
- Wound
- Skin breakdown
- Skin problems

☒ Goal Met

☐ Goal not met: _____
1. Abrasion 8. Discolored 15. Skin Tear
2. Amputation 9. Dislocation 16. Rash/Swelling
3. Avulsion 10. Erythemia 17. Stab Wound
4. Burn 11. Fracture 18. Swelling
5. Contusion 12. Gunshot 19. Ulcer
6. Crepitus 13. Hematoma 20. Weeping
7. Crusting 14. Laceration 21. Other



☐ Photos taken ☐ Deferred due to acuity
Distal CMS: + or - (if - see nurses notes)

10) **Infection** free as evidenced by..
- No signs or symptoms
- Negative history of MDRO

☒ Goal Met

☐ Goal not met: _____
☐ Fever ☐ Hypotensive ☐ Tachycardia
☐ History of _____
☐ Isolation Precautions
Type _____

11) **Activity level** maintained as evidenced by
- Absence of falls
- Low fall risk (less than 25)
- Effective use of assist devices
- Absence of spinal injury

☒ Goal Met

☐ Goal not met: _____
☐ C-Collar ☐ Backboard
On _____ Off _____
Off _____ Cleared by _____ Time: _____
☐ Fall Risk: Mod/High
☐ Preventions: a. _____

12) Effective **Communication (psychosocial)** as evidenced by
- Participation in plan of care
- Voices feelings and concerns
- Follows safety instructions
- Appropriate behavior
- call light
- Denies SI or HI
- Denies Domestic Violence

☐ Goal Met

☐ Goal not met: Lack of hearing
☐ Domestic Violence +
☐ May harm self or others
Interventions in place:
☐ Constant observer
☐ Personal belongings removed
☐ Visible by staff
☐ Family at bedside
☐ Unable to follow safety instructions
☐ Communication Barriers:
☐ Cognitive ☐ Hearing Loss
☐ Language: _____
Interpreter provided:
☐ Cyracom ID: _____
☐ Sign language: _____
☐ Friendly voice: _____

Learning Preference:
☐ Verbal ☐ Written
☐ Demonstration
☐ Unable to assess

Immunizations current:
Peds: ☐ Yes ☐ No
Last Tetanus _____

RN: _____ Block Print: 18316 Date: 09/01/14 Time: 1915

ADMISSION/TRANSFER/DISCHARGE

Previous unmet goals now met: _____
Status of unmet goals at disposition: Admission

Date: 9/1/14 Time: 2210
T: 37.1 C
HR 90 RR: 14
B/P: 151/70
SAT: 99% RA
PAIN: 0 /10

ADMISSION: Rm 2116 Time 2210
Report to Jenny ED Time 2215
☐ Gurney ☐ WS ☒ Monitor ☐ IVs infusing x _____
Accompanied by RN + Transporter
Belongings: ☐ None ☐ With Pt
☐ Home with _____
☐ Envelope: # _____
Medications: ☐ None ☐ With Pt
☐ Home with ☐ Pharmacy

TRANSFER to _____
Time _____
☐ Admission, Transfer and Discharge Forms Completed
Mode of transport:
☐ ALS ☐ BLS ☐ Car
☐ CCT ☐ CHET
Belongings:
☐ None ☐ With Pt ☐ Home

☐ **IV D/C'd, catheter intact. No redness of swelling at site.**

DISCHARGE Instructions given:
☐ Patient ☐ Family or SO ☐ Nursing Home
☐ Recipient verbalizes understanding
☐ Crutch training ☐ Additional inst. _____
☐ Rx to Patient or Other ☐ Discharge Med. list given
☐ Work or School release given

☐ Stable at discharge
☐ Orientation normal for Pt.
☐ Amb. ☐ W/C
☐ Carried ☐ BLS
☐ Taxi voucher ☐ Bus token
☐ Shuttle
Accompanied by
☐ Self ☐ Family/SO ☐ Parent
Other: _____

☐ AMA
☐ Eloped
☐ Expired

☐ Morgue:
☐ Mortuary
☐ Coroner

Resources Provided:
☐ Nutrition ☐ PLT
☐ Case management
☐ Social Services for _____
Referrals: ☐ MD/Clinic for follow up appointment
☐ Community Resources _____

RN _____ Elsie Ubarra, RN Date 9/1/14
Printed Name/Corp. ID 15 24 95 Time _____

6E

Fall Interventions

UNIVERSAL
Orientation to call light
Environment - No spills, clear pathways
Educate - Call Don't Fall
Personal items in reach
Safe bed exit
Bed in low position
Bed brakes locked
Moveable equipment brakes locked
Non-slip footwear
Side rails up
Anticipate effects of medications
Walker/cane available if needed

MODERATE/HIGH RISK
a. All Universal Interventions
b. Yellow Fall Risk arm band clip
c. Focused rounding & toileting offered
d. Patient within arm's reach while toileting
e. Other: See nursing narrative.

Unsteady Gait/Weakness/Difficulty Transferring
f. Assist with all ambulation and transfers using safe patient handling

Unaware of Own Limitations or Confused or Gets Out of Bed
g. Bed/chair alarm
h. Schedule deliberate assisted toileting
i. Constant observer
j. Other: see nursing narrative

Normal Pediatric Vital Signs

Normal Respiratory Rates by Age

Age	Breaths per Minute (At Rest)
Infant (1-12 mo)	30 to 60
Toddler (1 to 3 years)	24-40
Preschool (4-5 years)	22-34
School-age (6-12 years)	18-30
Adolescent (13-18 years)	12-16

Normal Heart Rates by Age

Age	Beats for Minute
Infant (1 to 12 mo)	100-160
Toddler (1-3 years)	90-150
Preschooler (4-5 years)	80-140
School-age (6-12 years)	70-120
Adolescent (13-18 years)	60-100

Lower Limit of Normal Systolic Blood Pressure by Age

Age	Lower Limit of Normal Systolic Blood Pressure
Term neonate (0-28 days)	>60 mm Hg or strong central pulse
Infant (1-12 months)	>70 mm Hg or strong central pulse
Child 1-10 years	>70 + (2 x age in years)
Child ≥ 10 years	>90 mm Hg

family member Rosalind (858)254 5931 (7)

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RIVES, BOBBYE J
MRN:200251338 DOB:10/23/1927 F/86
09/01/14 ED ACCT: 102074264
MACCORMICK, RONALD JAMES
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

DATE OF SERVICE: ______

EMERGENCY/URGENT CARE CENTER DEPARTMENT NURSING FLOWSHEET

Medication (PO/PR/SC/IM/IVP) — **Post Medication Reassessment**

Time	Medication	Dose	Route	Site	Initials	Time	B/P	HR	RR	Sat	Pain	Other	Initials

Start	IVPB/SOLUTIONS/ADDITIVES/ BLOOD	Gauge	# of Tries	Labs Drawn	Site	Dose	Rate	Initials	Amt Infused	C=complete I=infusing	Time	Initials
1915	NS bolus 1000mls	#20	1	yes	Lt FA	1000	WO	[illegible]	Fl	C	2045	[illegible]

TIME	NURSING NOTES	INI
1815	Report received from EMS. Hx of diarrhea, nausea & vomiting x 24 hrs. Denies fever. Hard of hearing. Family aware of transport	[illegible]
1915	IV inserted Lt FA. NS bolus initiated. Family @ bedside updated on plan of care	[illegible]
1925	[illegible] received from [illegible] [illegible] [illegible] plan of care	[illegible]
2045	Urine specimen sent to lab dip [illegible]	[illegible]
2105	[illegible] of blood culture [illegible] by phlebotomist [illegible]	[illegible]

Time	1810	1915		
B/P	192/86	177/80		
HR	102	107		
Rhythm				
RR	18	20		
O2 Sat	99	99		
O2	RA	RA		
T / Source	36.7 TA			
Pain	0			
Sedation				
I / O				
CC Time				
Initials	[illegible]	[illegible]		

☐ POSS ☐ RASS ☐ MRS — Total O2 Time — Total Critical Care Time

Signature: [signature]	Initials [illegible]	Signature: Elsie Ubarra, RN	Initials [illegible]
Printed Name/Corp ID 181366	Date/Time 09/01/14	Printed Name/Corp ID 152495	Date/Time 9/1/14
Signature:	Initials	Signature:	Initials
Printed Name/Corp ID	Date/Time	Printed Name/Corp ID	Date/Time

100-7010-7727SW (Rev. 5/6/13)

6E

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Page 4 of 4

EMERGENCY DEPARTMENT NURSING NOTES

RIVES, BOBBYE J
MRN:200251338 DOB:10/23/1927 F/86
09/01/14 ED ACCT: 102074264
MACCORMICK, RONALD JAMES
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Medication (PO/PR/SC/IM/IVP)						Post Medication Reassessment							
Time	Medication	Dose	Route	Site	Initials	Time	B/P	HR	RR	Sat	Pain	Other	Initials
2145	Morphine	1gm	SIVP	(DN	jth								

Start	IVPB/SOLUTIONS/ADDITIVES/ BLOOD	Gauge	# of Tries	Labs Drawn	Site	Dose	Rate	Initials	Amt infused	C=complete I=infusing	Time	Initials
2150	Flagyl 500mg	20	—	—	(DN	500mg	100	jth	500mg	C	2245	jth

TIME	NURSING NOTES	INI
2115	Brought to US	jth
2135	Back from US pt awake	jth
2145	Antibiotic started and	
	monitor pt	jth
2215	Pt able to tolerated antibiotic	jth
2241	brought to CAT for CT head	jth
0805	Blood extracted from pt	
	to lab	jth
2245	SBAR heard from Jennifer	
	received by Uyen RN	jth

Time	2110	2210		
B P	141 / 87	139 / 90		
HR	86	90		
Rhythm				
RR	18	16		
O2 Sat	99%	99%		
O2	2L	2L		
T Source	—	98.4		
Pain	0	0		
Sedation	1	1		
I / O				
CC Time				
Initials	jth	jth		
☐POSS ☐RASS ☐MRS			Total O2 Time	
			Total Critical Care Time	

Signature: Elsie Ubarra, RN	Initials jth	Signature:	Initials
Printed Name/Corp. ID	Date/Time 9/1/14	Printed Name/Corp. ID	Date/Time
Signature:	Initials	Signature:	Initials
Printed Name/Corp. ID	Date/Time	Printed Name/Corp. ID	Date/Time

1ED

6E

Scripps Health
Facility: Encinitas
RIVES, Bobbye J
MRN#: 200251338
DOB: 10/23/1927
Age:86 Sex: F

ED INTAKE ASSESSMENT REPORT

Acct#: 102074264
Attending MD: Maccormick, Ronald J
Admit Date: 09/01/2014
Loc: E E

Page: 1
Print : 09/01/14 18:28
REPORT ID: SFLW008s-AGG63

Patient: RIVES, Bobbye J **MRN#: 200251338**

MDRO: UNKNOWN

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
ACCT:102074264
09/01/14
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

ALLERGY	REACTION
- ****No Known DRUG Allergies****	
- ****No Known FOOD Allergies****	

Entered By: Wahl, Heather L, RN Date/Time: 09/01/14 18:25

ED Intake Report

Chief Complaint/Presentation (Pts words)	Note

Generalized weakness and vomiting x 24 hours. alerted neighbors and EMS called.

PMX: htn, dm II, hearing aids.

Patient feels like hurting self or other	No

ED TB report.

No signs or symptoms of TB	Y
TB Risk	No

ED Medication List2.

ED Medication List2	Note

CURRENT MEDICATION LIST;(include dose, frequency, and last dose taken if known):
Glipizide
Zetia
atrovastatin

( )None

Provided by ( ) Patient ( )Other: ( ) Unable to Obtain

DISCHARGE MEDICATION LIST;(include dose, frequency, and next dose due):

6E

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

ED Medication List2. (CON'T)

Aftercare Instructions:

( ) Continue your current medication schedule.

( ) These medications have been changed or added:

Notify your primary care physician within the next 24 hours about any new medications that have been prescribed today. If you have any questions about the medications you have been prescribed, then please contact the Emergency Department or Urgent Care Center.

The medication history above was provided by the patient or patient's representative to the best of their knowledge.

HEIGHT AND WEIGHT.

Weight kg	65
Weight Obtained	Stated
Height (cm)	155
Body Mass Index Calculation	27.05
Body Surface Area	1.6400

MORSE FALLS RISK.

History of Falls - Yes	25
Secondary Diagnosis - No	0
Ambulatory Aide - None/Bed Rest/Wheel Chair	0
IV/Saline Lock - Yes	20
Gait Transferring - Weak	10
Mental Status - Oriented to own ability	0
Fall Risk Total Score	55

6E

Scripps Encinitas

HISTORY AND PHYSICAL

PATIENT: RIVES, BOBBYE J
MR#: 000200251338 ACCT#: 000102074264
DATE OF ADMISSION: 09/01/2014

PRIMARY CARE PHYSICIAN:
Not listed.

CHIEF COMPLAINT:
Weakness and abdominal pain.

HISTORY OF PRESENT ILLNESS:
Mrs. Rives is a very kind 86-year-old female with a history of coronary artery disease, status post stenting in 2007; diabetes; hypertension; dyslipidemia; glaucoma; severe hearing loss; and CKD, stage 3, who presents to the ED with weakness and abdominal pain. Due to her severe hearing loss, she is unable to give an accurate history and her family is not present during the interview. She does state that she does have some unusual abdominal symptoms and some right hip pain, although it is unclear whether she fully understands the questions during my interview. Based on chart review, it seems that she has had some issues with estrangement and a restraining order with regard to her daughter, but the details of that currently are unclear.

CURRENT MEDICATIONS:
Taken from her most recent hospitalization.

1. Aspirin.

2. Iron.

3. Protonix.

4. Metoprolol.

5. Metformin.

6. Zetia.

Please note that this medication may not be up-to-date as it was taken from 2011, and she currently is unable to give her pharmacy information.

ALLERGIES:
NO KNOWN DRUG ALLERGIES.

PAST MEDICAL HISTORY AND SURGICAL HISTORY:
1. Diabetes.
2. Hypertension.
3. Dyslipidemia.
4. Glaucoma.
5. Generalized anxiety disorder.
6. Chronic kidney disease, stage 3.
7. Coronary artery disease, status post TAXUS stent to the LAD.
8. Right knee surgery.

FAMILY HISTORY:
Noncontributory.

SOCIAL HISTORY:
Positive for previous tobacco use. No alcohol abuse. There is a history of a positive THC on a urinary tox screen from 2011. Currently, she is retired, and her next of kin and DPOA is unclear.

REVIEW OF SYSTEM:
Unable to be obtained due to her severe hearing loss.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 184/72, pulse 125, respiratory rate 14, and O2 saturation 100% on room air.
GENERAL: The patient appears disheveled, but not in distress. She does not have any obvious skin lesions. She is warm to touch.
HEENT: Head: She is atraumatic and normocephalic. Eyes: There is evidence of prior cataract surgeries. Conjunctiva is clear. Oropharynx: She has poor dentition, but no evidence of abscess.
NECK: No masses. No thyromegaly.
LYMPH NODES: Negative for cervical or supraclavicular lymphadenopathy.
CARDIOVASCULAR: Tachycardic. 2/6 systolic ejection murmur. A gallop was present.
LUNG EXAM: Clear to auscultation and percussion.
BACK EXAM: Appears normal. Nontender.
ABDOMEN: Soft, nondistended, and nontender. No hepatomegaly.
EXTREMITIES: No cyanosis. No clubbing. Bounding pulses throughout.
NEUROLOGIC: She seems to be alert and oriented, although it is difficult to obtain a thorough neurologic exam.

LABS AND IMAGING:
CT abdomen and pelvis without contrast shows no acute abdominal or pelvic processes. A colonic diverticula was present, but with no evidence of diverticulitis. The uterus was not present. The gallbladder was unremarkable. There was evidence of a new subacute compression fracture of L2 with mild retropulsion and a 50% height loss. There was also new mild to moderate T9 compression fracture with no retropulsion noted. An abdominal ultrasound was ordered and that was negative for any acute process.

Sodium 143, potassium 5.0, chloride 109, bicarb 20, BUN 30, creatinine 1.6, glucose 238, and calcium 10.2. Magnesium 2.3, albumin 4.5, total protein 8.9, and total bilirubin 1.0. AST 49, ALT 40, alk phos 169, CK-MB 3.56, and troponin 0.031. Lactate 2.8. Urinalysis negative. ProBNP 3350. White count 23.1, hemoglobin 14.6, hematocrit 42.0, and platelets 424.

ASSESSMENT AND PLAN:
1. Leukocytosis. The etiology of this leukocytosis is unclear. It appears that she may have an underlying infection, although the source is yet to be determined. Workup to this point includes a chest x-ray, which was unrevealing. CT of abdomen and pelvis, which did not show any evidence of infection. An abdominal ultrasound, which does not show any evidence of

infection. She does have a slight transaminitis, but again liver imaging was unremarkable. She did receive one dose of ceftriaxone 1 g IV x1 and Flagyl 500 mg IV x1 in the ED. She is not hypotensive nor she at risk for MRSA, so we will withhold vancomycin for now. Blood cultures, urinalysis, urine culture, stool ova and parasites, stool culture, and C. diff were all sent in addition to an ESR, CRP, and a lactate. A CT head is also being ordered. We will continue to hydrate her aggressively. She does appear to be perfusing her end organs without issue based on her urine output. Other etiologies to consider include osteomyelitis, TB, and meningitis. Given her hemodynamic stability, we will defer lumbar puncture to the morning given her newly diagnosed compression fractures. In addition, it is possible that this could reflect some new onset neoplasm, although this would be low on the differential. Also to be considered would be an atypical pneumonia, although she has very few symptoms that would suggest this.

2. Compression fractures of L2 and T9. This was diagnosed incidentally on CT scan. Currently, she does not appear to have any neurological deficits related to this mild retropulsion. We will consult Orthopedic Surgery in the morning for potential surgical options, although given her current status, she may be a poor surgical candidate.
3. Coronary artery disease. She is status post stent to the mid left anterior descending in 2007. Her outpatient cardiologist was noted upon arrival. Her cardiac enzymes were negative x1.
4. Diabetes. We will start her on an insulin sliding scale therapy while she is an inpatient. Her glucose upon arrival was in the low 200s.
5. Chronic kidney disease. Her creatinine upon arrival was 1.6. Back in 2011, it seems her creatinine was around 1.5, and she appears to be at baseline. We will continue to hydrate her as above and monitor her urine output closely.
6. Elevated proBNP. It is somewhat elevated to 3350, although this may be falsely elevated due to her chronic kidney disease. She does not appear to be fluid overloaded, although she has not had an echocardiogram recently, this may be worthwhile in the morning.
7. Transaminitis. The etiology is unclear, and she has had a CT and an ultrasound as part of this workup. This does not appear to be contributing to her leukocytosis, although we will also continue to monitor this as well. We will send a hepatitis panel as part of this workup.
8. Deep venous thrombosis prophylaxis. She will be on heparin subcutaneous and SCDs for DVT prevention.
9. Code status: She is full code, full care.

The plan has been discussed with the patient and staff.

DICTATED BY: JAMES T KIM, MD

JTK:Spheris77732 C: 09/02/14 02:08 CONFIRMATION #: 521497
D: 09/01/14 22:48 T: 09/02/14 02:08 DOCUMENT: 201409020990081200
Authenticated and Edited by James T. Kim, M.D. On 9/08/14 6:37:52 PM

Scripps

PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.
9/2/14 955AM	PCM 86 ♀ c̄ h/o CAD (stent 07) DM2 TBP adm. 9/1 with weakness and abd. pain Extensive w/u done. CT abd ⊖ for infection/mass/stone new comp fx L2 T10 Sono ⊖ lactic acid 2.8 PMH CT brain NAD. lipase 126 ↓ hearing P/S tunny hurts "a little" u/a ⊖ NKA. No CP or SOB. WBC 23,100 No tob/ETOH PE/ 36.9 110 150/77 20 sat 99 NC/NT PERRL EOMI Oroph clear trach midline. Lungs clear Kidney w/o CVA BST ϕ mass or tenderness except in LLQ (mild) No CCE. SCDs. ↓ hearing Lact 3.8 WBC 26,400 147 116 21 12% Mg 2 pH 369 K 4.2 19 1.4 Ca 8.4 Sm 0.8 AP WNL lactic acid ↓ 1.6 Imp Abd. pain c̄ delay dx/tx, ↑WBC, tachy Sent ⊖ CT/sono Suspect gastroenteritis not diverticulitis Sent may cover c̄ abx for day. Plan/ IV fluids IV abx Start clears

Scripps

PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.
9.2.14	Cardiology Consult. (f Dr. Arcadia)
	Problem List:
	1. fatigue & abdominal pain
↑ESR/CRP	c ↑ lactic acid
	leukocytosis
	↑o infection
	2. dehydration
	3. H/o CAD s/p STEMI x LAD → STEMI
	& H/o DCM,
	5. DM.
	6. HC.
	5. ↓ Hgb
	6. CKD.
	Rec — IVF
	— cardiac — wise — stable → Sign off
	Pray

1PN

100-8720-016SW (1/20/11)

65

Scripps

PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.

9-2-14/1400 : Audiology: Bilateral hearing aid check. Social worker reports continuous "beeping" of hearing aids. Otoscopy clear bilaterally ruling out occluding cerumen interfering with hearing and hearing aid (HA) function. Listening check and visual inspection of HAs reveal cracked tubing on lateral surface of earmolds, both HAs and both batteries dead. Rhapsody Behind-the-Ear HAs from Nu Ear.

Replaced tubing, both hearing aids, and batteries. Provided batteries for patient's stay. Cleaned both hearing aids. Listening check revealed both HAs functioning appropriately with similar output, all three listening programs function, as well as volume control.

Returned HAs to patient. Communication significantly improved, patient still needs close, face-to-face communication, with slow rate of speech for best understanding. Patient cannot hear Right HA output or function signals.

HAs continue to feedback ("beep") while patient is wearing them due to reflection from pillows behind head.

Recommendation: Audiologic Evaluation upon discharge to evaluate suspected decrease in Right ear hearing levels, or bedside. Should otologic involvement be suspected due to patient's medical condition and/or treatment.

Catherine A. Falbo, Aud

1PN

100-8720-016SW (1/20/11)

GE

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PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
6SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.
9-3-14	PCU
850	S. Pt. is better Audiology note reviewed Today she says her tummy was "sore" yesterday but not today. No N, V, diarrhea No SOB or CP PE/ NAD. Very hard of hearing. 37.1 118 18 129/64 97 (RA) NC/AT PERRL EOMI Oroph clear Trach midline Lungs clear RRR no M/R/G BS+ soft nontender no HSM + 45M / warm No CCE. SCDs Moves all 4 ext. Alert Hct 35.2 WBC 25,600 (sl. ↓) 143 | 115 | 17 sl Plt 339 K 4 | 21 | 1.2↓ alb 3.1 Ca 8.4 Mg 1.9 Glu 0.6 AP 132↓ Blood c/s ⊖ Urine ⊖ Imp. Suspect med-mod duodenulitis or gastroenteritis LUQ pain has abated but still has tachycardia & ↑ WBC Plan/ Cont IVFs Cont abx Clears → may advance Send. Labs/exam Foc. SVC to see

1PN

100-8720-016SW (1/20/11)

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PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.
9/3/14 13:50	Physical Therapy PT orders received. PT eval completed. Please refer to Centricity for details. Pt currently @ CGA for bed mobility, SBA for transfers, & CGA gait X 150' w/ AD. Pt would benefit from a FWW for safety during gait - pt owns one @ home. D/C rec: pt states she lives alone however recommend assisted living or placement as I have concerns regarding her safety & ability to care for herself independent D. Ellen Chan, PT

Scripps

PROGRESS RECORD

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Note progress of case, complications, consultations, change in diagnosis, condition on discharge, instructions to patient.
9-4-14 905A	Pcn
	doing well.
	eating w/o N, V, diarrhea
	no c/o pain at all
	PE/ lying flat, asleep when I arrived
	37.1 96 18 122/65 Sat 97 (RA)
	HEENT ⊖
	neck. midline
	lungs clear
	hrt w/o S3
	abd soft. ↓ rare ↓ tenderness
	↓ BS
	d hearing o/w wn. fecal
	blood c/s ⊖ x2
	hct 38
	wbc (25,100) 139 | 111 | 12 72 G/S 3.2
	plt 305K 4.2 | 23 | 1.1
	U/A ⊖
	CXR ⊖
	CT abd/pelv - diverticuli w/o signs infection
	98 fluid s/p hysterectomy

Authenticated by
~~Matthew J. Horn, M.D.~~
On 09/10/2014 11:21:25 AM

1PN

100-8720-016SW (1/20/11)

GE

Scripps Memorial
Hospital Encinitas

PROGRESS NOTE

Hospital Day # ________

RIVES, BOBBYE J
MRN:200251338 DOB: 10/23/1927 F/86
09/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Date/Time	Subjective / Events: Feeling better. ☒ Meds Reviewed
9/4/14	

Exam: VS: T: 36.6 (Afeb) P: 105 R: 17 BP: 155/71 O2 Sat: 96% RA

General: ☒ NAD Wt: I/O:

CV: ☐ RRR, no m/g/r, no JVD, no edema Sinus tachy.

Resp: ☒ CTAB, no rhonchi, rales, or wheeze

GI: ☒ Soft, NT/ND, NABS (+) Mild discomfort

Mskl: ☒ No clubbing/cyanosis, or deformities

Data: ☒ The following labs and imaging were personally reviewed/interpreted Albumin (3.2) UA-ø

☐ CXR 25.6 → (25.1) 13.0 / 38.1 309 139 (111) 12 / 4.2 23 (1.1) 72 AP (140) ← 131 ← 155

☐ EKG/Tele other LFTs wnl

wbc 1.2 ← 1.4 ← 1.6

BCx NGTD
Stool Cx (P) Mg 1.8

A/P: (Please list diagnoses in order of severity and indicate New, Improved, Stable, Worsening and/or POA)

86 F c̄

1) Leukocytosis / Tachycardia - Possibly mild diverticulitis vs gastroenteritis but unseen on CT - on PO Augmentin
- ✓ C.Diff, D-dimer - consider V/Q scan if (+)
- if w/u (-), consider Heme consult.

2) ARF on CKD - Improved c̄ IVF

3) DM2 - cont Glipizide, SSI

4) HTN - cont Norvasc

5) CAD - cont ASA, resume Metoprolol, Atorvastatin

6) L2 + T9 Comp. Fx's - consider orthopedic consult

-D-dimer

Foley: ☒ None ☐ Present/indication: ________ CVC/PICC: ☒ None ☐ Present/indication: ________

DVT Prophylaxis: ☒ SCDs ☒ LMWH ☒ SQ Heparin ☐ Full anticoagulation ☐ Contraindicated

Plan of care discussed with: ☐ consultant ☒ PCP ☐ DPOA ☐ Family

Prolonged Care time spent in direct (face-to-face) patient contact: ______ minutes.

Risk of morbidity/mortality: ☐ Low ☒ Mod ☐ High

MD # 592279 **MD Signature** [signature] **Date** 9/4/14 **Time** 17:00

Dabestani

1PN

LE

SOCIAL SERVICE ASSESSMENT

Admission Date: 9-6-14 Is Resident a readmit?:

A. IDENTIFYING INFORMATION

Name: Bobbye Rives D.O.B.: 10-26-29 Age: 84 Marital Status:

Financial Resources: ☒ Medicare ☐ MediCal ☐ Private Ins. ☐ Private Funds ☐ Managed Care

B. PSYCHOSOCIAL EVALUATION:

	Yes	No	At Times
1. ORIENTED TO:			
Self	☒	☐	☐
Others	☒	☐	☐
Place	☐	☐	☐
Time	☐	☐	☐
Center	☐	☐	☐
Comments:			
2. MEMORY OF:			
Past	☐	☐	☐
Present	☐	☐	☐
Comments:			
3. MOOD LEVEL:			
Anxious	☐	☒	☐
Agitated	☐	☒	☐
Depressed	☐	☒	☐
Lethargic	☐	☒	☐
Comments:			
4. BEHAVIORS:			
Wanders	☐	☒	☐
Verbally Abusive	☐	☒	☐
Physically Abusive	☐	☒	☐
Social Inappropriate	☐	☒	☐
Comments:			

5. STRENGTHS:

	Yes	No	At Times
6. PSYCHOTROPIC MEDICATIONS:			
Antipsychotic	☐	☒	☐
Antidepressant	☐	☒	☐
Antianxiety	☐	☒	☐
Comments:			

7. PHYSICAL RESTRAINTS:
Type:
Reason:

8. RELATES TO OTHER RESIDENTS:			
Friendly	☒	☐	☐
Withdrawn	☐	☒	☐
Hostile	☐	☒	☐
Comments:			
9. RELATES TO THERAPEUTIC REGIME:			
Cooperative With Staff	☒	☐	☐
Accepts Treatment?	☒	☐	☐
Comments:			
10. EATING / WT PROBLEMS:	☐	☒	☐
Comments: Regular NAS, LBS			
11. CONTINENT:			
Bladder	☒	☐	☐
Bowel	☒	☐	☐
12. RESIDENT ACCEPTS PLACEMENT:	☒	☐	☐
Comments:			
13. HOSPICE INVOLVED:	☐	☒	☐
Comments:			

C. RELEVANT PAST HISTORY

Visually impaired, glaucoma, Hearing impaired, hearing aids

D. DISCHARGE PLANNING:

Discharge goal:
Prior living arrangements: 363 Cerro St. Encinitas, CA. 92024 Still available?
Resident's attitude toward discharge:
Family's attitude toward discharge:
Anticipated length of stay 2-3 weeks

Signature Arthur Waller MD Date 9-8-14

61

Finding	Service Date/Time	Result	Charted Date/Time	Charted By
Psychosocial Problems CP.				
Anxiety		Active	09/06/14 02:03	6-164367, RN-NG
family issues				
Living Situation		Active	09/06/14 02:03	6-164367, RN-NG
Unsafe Home Environment				
Psychosocial Interventions CP.				
Social Services consult		Active	09/06/14 02:08	6-164367, RN-NG
Provide emotional support		Active	09/06/14 02:08	6-164367, RN-NG
Provide family support		Active	09/06/14 02:08	6-164367, RN-NG
Psychosocial Intervention Note		Y	09/06/14 02:08	6-164367, RN-NG

9/5/14 patient reports that she was living in an unsafe home environment prior to coming into hospital and prior to obtaining restraining order against he daughter. Patient reports the daughter was physically and emotionally abusive to her. Pt also reports her daughter may have some mental instability. The patient's nephew and niece have stepped in and helped the patient since the event and prior to coming into hospital. Patient was very upset and in tears regarding her family situation and wishes she could work things out with her daughter. May need social work involved in further home care.
PCorrington, RN

Psychosocial Goals CP.				
Psychosocial Goals		Progress	09/06/14 02:08	6-164367, RN-NG

Psychosocial Goals per Core Standard

Effective communication, as evidenced by:
* Appropriate affect and behavior
* Expressing feelings and concerns
* Interacting with staff and participating in plan of care
* Progressing toward established education goals

Free of restraint, demonstrating appropriate, safe behavior as evidenced by:
* Follows safety instructions, i.e.
  - Calls for assistance before getting out of bed
  - Does not disturb medical equipment and lines
  - Uses call light

Psychosocial Goals - Noted Exceptions/Additions
(Enter patient-specific goals below)

Finding	Service Date/Time	Result	Charted Date/Time	Charted By

Social Work Interval Notes. 09/02/14 16:26

SW INTERVAL NOTES. (CONTINUED)

Pt. nephew visiting Pt, and Pt gives permission for MSW to speak freely with her nephew (as her hearing aides are not working well).

Pt. nephew reports Pt. had temporary restraining order done 2 weeks ago against her daughter, after Pt. daughter became physical with Pt. Pt. adds that "I finally came clean and told my MD about Larnita hitting me". MSW confirmed with Pt. and Ralph that Pt. will be made a "no info" in the hospital, and they both like and agree to this option for protection. MSW relayed this safety measure to bedside RN Jeanette and IN Lerida. MSW also updated with Lupe in Access Dept. facesheet with advance directive surrogates (listed above). MSW also placed advance directive in Pt. chart (sent from Pt. lawyer's office), also a addendum note from lawyer stating that Pt. daughter is not to have any power of Pt. estate; Pt. lawyer has also sent this letter to SD Sheriff's (to let them know that Pt. is severely hearing impaired and under stress over daughter).

NO INFO

Pt. nephew Ralph says he is going to get Meals on Wheels for Pt. and knows how to contact this agency. Ralph agrees to participate in DC plan of Pt. and will contact Pt. primary surrogate (niece Beverly).

MSW facilitated audiology consult (with order from MD Horn) and RN Jeanette reports this was very helpful (at end of day). Batteries were replaced and cracked tubes were replaced by Dr Fabian.

Plan: Pt and Pt. nephew, advised of the role/availability of Social Services at this facility; Social Services will continue to follow p.r.n.
Still awaiting call back from APS worker to clarify case and inform APS that Pt. has been admitted.

Oceanna Gage MSW

6D

Task

MDT

Task

Subject MDT

Case Note Type MDT

CM received the following information about the client's status from ST Welinsky.

The client's daughter, Larnita Petitte (SA), has moved out of the client's home and into the home of a friend in the area (address unknown). The client is being care for by her neighbor Rosita Cobal (760-846-1842) who had been previously been referred to as "Jovita". The client stays with Rosita at night but spends the day at her own home. The client's nephew, Ralph Sanders (RP) is also assisting with the client's care.

Client is her own decision maker. Client has a long HX of financially supporting the SA. It is unknown if she is continuing to do so.

Regarding Case for Bobbye Rives on Feb 2 2011

Owner Shefali Dua

Duration

Priority Normal

Actual Start 3/3/2011

Due 3/3/2011 4:00 AM

Legacy Fields

Legacy ID 1,302,878

Legacy Client ID 154,190

Last Modified On 3/3/2011

Last Modified By

Last Modified By ID pdowney

Notes

Scripps Health | NURSING CARE PLAN SUMMARY REPORT | Page: 35
Facility: Encinitas | Print : 08/19/15 12:52
RIVES, Bobbye J | Acct#: 102074264 | REPORT ID: ZFLW001S-AGG04
MRN#: 200251338 | Attending MD: Dabestani, Ardeshir A
DOB: 10/23/1927 | Admit Date: 09/01/2014
Age:87 Sex: F | Disch: 09/06/2014

Finding	Service Date/Time	Result	Charted Date/Time	Charted By
Psychosocial Problems CP.				
Anxiety		Active	09/06/14 02:03	6-164367, RN-NG
family issues				
Living Situation		Active	09/06/14 02:03	6-164367, RN-NG
Unsafe Home Environment				
Psychosocial Interventions CP.				
Social Services consult		Active	09/06/14 02:08	6-164367, RN-NG
Provide emotional support		Active	09/06/14 02:08	6-164367, RN-NG
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Psychosocial Goals CP.				
Psychosocial Goals		Progress	09/06/14 02:08	6-164367, RN-NG
Psychosocial Goals per Core Standard				
Effective communication, as evidenced by: * Appropriate affect and behavior * Expressing feelings and concerns * Interacting with staff and participating in plan of care * Progressing toward established education goals				
Free of restraint, demonstrating appropriate, safe behavior as evidenced by: * Follows safety instructions, i.e. - Calls for assistance before getting out of bed - Does not disturb medical equipment and lines - Uses call light				
Psychosocial Goals - Noted Exceptions/Additions (Enter patient-specific goals below)				

Scripps

PATIENT DISCHARGE / INTERFACILITY TRANSFER INSTRUCTIONS

RIVES, [illegible]BYE J
MRN:200251338 DOB: 10/23/1927 F/85
08/01/14 ACCT:102074264
KIM, JAMES T MD
SCRIPPS MEMORIAL HOSPITAL, ENCINITAS

Nurse to complete asterisked items (*). Physician to complete shaded areas.

*Discharged to: ☐ Home ☐ Home with Home Health ☐ Acute Rehab ☐ Assisted Living ☐ Board and Care ☒ SNF
☐ Other: Las Villas de Carlsbad
*Mode of transport: ☒ Auto ☐ Ambulance ☐ Wheelchair Transport ☐ Other

Follow up Appointments

Primary Physician: Dr. Moli Cava Call to be seen in 7 days, Phone: (619) 221-4490
Specialty Doctor Bingfeng Dv Reason Cardiology see in 14-21 days, Phone: (760) 330-6660
Specialty Doctor Jamieson Glenn Reason Orthopedic see in 7-10 days, Phone: (760) 230-5188
Specialty Doctor ☒ Reason see in ___ days, Phone:
Diet: ☐ Regular ☒ Cardiac ☒ Diabetic ☐ 2gm Sodium ☐ Soft ☐ Other:
(Circle) Diet/swallow precautions or instructions:

Activity: No restrictions unless noted below

☐ May resume all normal activities in ___ (circle) days / weeks
☐ No shower until ___ ☐ No bath until ___
☐ No lifting more than ___ pounds ☐ Weight bearing restriction:
☐ Until further instructed by MD, walk with ☐ Walker ☐ Crutches ☐ Other:
Driving: ☐ In ___ days ☐ when cleared by MD Work: ☐ In ___ days ☐ when cleared by MD
Labs: ☐ PT/INR in ___ days ☒ Other labs/procedures: √ CBC + BMP in 3 days
*Incision Instructions: Keep wound clean and dry ☐ Okay to leave open to air
*Notify surgeon for fever, chills, increased drainage, redness, and/or pain.
*Wound Care: Pressure Ulcer Present: ☒ No ☐ Yes Stage/Location:
Instructions:

C. Diff precautions

FAX 760-720-3194 Attn:

*Other Information / Instructions: * Do NOT Disclose ANY Pt. info, except to Pts Nephew - Ralph Sanders (714) 262-8378
- If discharge back pain, consider T-Spine Brace.
*Immunizations given in hospital as applicable: ☐ Flu ☐ Pneumonia ☐ Date given: (if known)

Continuing Care

For: ☐ RN ☐ PT ☐ OT ☐ Speech ☐ Wound ☐ Other:
*Agency: *Phone:
☐ Infusion of: *Agency: *Phone:
☐ Equipment: ☐ Oxygen at ___ liters/min. *Agency: *Phone:
Other equipment: *Agency: *Phone:

Information to be completed for next caregiver/SNF

Report called to: (760) 434-4322
☒ SNF Accepting MD Dr. Daniel Given Care Navigator Name/# Diane Slayton, RN
Time of last meal: Time of last pain medication: ☐ Confused/ forgetful
Foley catheter inserted (date): Incontinent: ☐ stool ☐ urine Last Bowel Movement:
Needs assist with: ☐ Bathing/dressing ☐ Eating ☐ Ambulation ☐ Other
Advanced Directive: ☐ No ☐ Yes ☐ Copy With Patient
Infection: ☐ MRSA ☐ C. Difficile ☐ VRE ☐ Other

PHYSICIAN SIGNATURE	DATE/TIME	PATIENT SIGNATURE	NURSE SIGNATURE	DATE/TIME
	9/6/14 @ 17:35			9/6/14

☐ Belongings sheet reviewed with patient
☐ Discharge instructions/medications reviewed with patient/family and copies given.

2DCIN

PHOTOCOPY ON DISCHARGE

Original: Chart Copy: Patient 320-8720-807 (11/11/13)

6D

INITIAL DISCHARGE ASSESSMENT

Name: Bobbye Rives Admit Date: 9-6-14 DOB: 10-23-29
Medical Record #: 13444 Physician: Given
Diagnosis: Sepsis, Rehabilitation, Int Inf Clostridium Difficile, Tachycardia NOS
Rehab Potential: Good ✓ Fair ___ Poor: ___
Admitted from: Scripps Encinitas Prior living arrangements: Lives at home

RESIDENT APPEARS TO BE:

✓ a. Long-term care without possibility of discharge.
✗ b. Short-term care. If yes, anticipated length of stay: ___
Previous community resources utilized: ___
In-home support services available: ___
Financial resources: ___
Resident's motivation to function in a more independent setting: (circle)
GOOD FAIR POOR
___ c. Unable to determine at this time.

DISCHARGE PLAN DISCUSSED WITH:

~~a. Resident~~
X b. Family, Responsible Party, Friend: (circle) Ralph Sanders nephew/DPOA (714) 262-8378
Name

Comments: ___

Signature: [signature] Date: 9-8-14

DISCHARGE PLANNING NOTES: ___

LVC000177

6D

SOCIAL SERVICE NOTES

Date	Time	All Entries Shall Be Signed with Name and Title
9-8-14		Room visit with Resident. SW introduced self and welcomed Resident to facility. Resident is alert, oriented, and verbally responsive, very pleasant, individual appears to be adjusting to facility placement. SW inquired about Resident's care. Resident expressed that her care is OK. Behavior is stable. No psychotropic medication in use. Insure what the discharge goal is for Resident. Resident anticipates returning home. SW will further discuss Resident's discharge planning with Resident's nephew. SW was informed by Nursing that Resident's nephew Kellen Sanders makes decisions for Resident.
9-9-14		SW received a phone call from Resident's nephew DPOA Kellen Sanders.

Last Name	First	Middle	Room No.	Attending Physician
Rivers	Bobbye		100	Given

LVC000178

6D

SOCIAL SERVICE NOTES

Date	Time	All Entries Shall Be Signed with Name and Title
		Ralph Sanders. Residents nephew, provided information regarding Residents prior living arrangements, social history, medical history etc. Resident lives in a two story condo. According to nephew Resident will require assistance with cooking meals. Nephew request a meeting to discuss Residents plan of care. Care plan meeting is scheduled for 9-15-14 at 10:30 a.m.
9-10-14		Left voicemail message with Adult Protective Services. Adult Protective Services returned call about Residents prior living arrangements with her daughter. Daughter was physically, mentally and financially abusive with Resident. Daughter has a restraining order and can

Last Name	First	Middle	Room No.	Attending Physician
Rivers	Bobbie		100	Aiken

LVC000179

SOCIAL SERVICE NOTES

Date	Time	All Entries Shall Be Signed with Name and Title
		not have any contact with Resident. AR's recommend and expressed that Resident would like to transfer to an AL or Board In Care in Orange County or LA/ Angeles area, closer to Residents nephews. Residents Monthly income is 3,000.00 — Jettie Walker LSW

Last Name	First	Middle	Room No.	Attending Physician
Rivas	Bobbye		100	Aiken

6D

Scripps Health
Facility: Encinitas
RIVES, Bobbye J
MRN#: 200251338
DOB: 10/23/1927
Age:87 Sex: F

SOCIAL WORK SUMMARY REPORT

Acct#: 102074264
Attending MD: Dabestani, Ardeshir A
Admit Date: 09/01/2014
Disch: 09/06/2014

Print : 08/19/15 12:55
REPORT ID: ZFLW001S-AGG11

Finding	Service Date/Time	Result	Charted Date/Time	Charted By
Social Work Interval Notes.	09/03/14 14:40			
SW INTERVAL NOTES.				
Social Work Interval Notes		Y	09/03/14 15:00	3-158975, SW CLN

Social worker madecontact with APS SWer Karen Dee 760-754-5807.
Karen reports that patient needs to hire some assistance at home, possibly 2 hrs a day to help with meals and cleaning. apparently, patient has been resistive in the past. Karen is not aware that niece Beverly is DPOA or if there is an actual document stating so. SWer informed Ms. Dee of letter from patient's attorney re: nephew Ralph Sanders 714-262-8378 is one of her Successor trustees and Agents under her Power of Attorney. ms. Dee expressed concern re: niece beverly and believed her to be aligned with daughter. Presently nephew appears to be the most involved and trustworthy.
SWer placed call to request facesheet be updated to reflect nephew Ralph as contact person.
T/C with nephew and discussed need for patient to have assistance at home. Ralph reports patient has told him she wanted to contact "Debbie" re: helping her at home. Ralph is in the process of getting in contact with Debbie and this writer also emailed him a list of homecare agencies.
Nephew states that patient will want to be in her own home which her husband had bought for them. Ralph to call SWer when he hears from Debbie. SWer conferred with IN and IN will arrange for Home PT, RN and ON.
SW to notify APS SWer Karen 760-754-5807 upon discharge.

Jill Moldenhauer LCSW

Social Work Interval Notes.	09/04/14 14:52			
SW INTERVAL NOTES.				
Social Work Interval Notes		Y	09/04/14 14:58	3-158975, SW CLN

SW follow up this am. SWer conferred with PT and it was stated patient is quite weak and unconditioned, could benefit from SNF. Patient would benefit from further instruction using a walker as well. If patient went home would require 24 hr. care.
T/C with nephew Ralph 714-262-8378 and he agreed SNF may be best option. conferred with IN and she will speak with patient re: SNF and also contact nephew.

Scripps Mercy Hospital

Social Service Record

RIVES, BOBBYE J
MRN: 200251338 DOB: 10/23/1927 F/83
02/16/11 ACCT: 916209018
CABREJOS, CLAUDIO MD
SCRIPPS MERCY HOSPITAL, SAN DIEGO

DATE	
2/17/11	P- Psychosis NOS (?) Anxiety
1245	I- met c pt. left message with APS Kathleen Walendzi 760-754-5952 - Spoke with Dr Baxter-Jones 858-629-9020 friend of family.
	R- 83 yo elderly widowed African American female. lives in own home with daughter "Rita" 62 yo lives with mother/pt since Feb '09. Pt describes daughter as being manipulative, stealing things being no help at home; there has been verbal abuse & physical abuse (mutual). Pt has difficulty hearing. Pt accusing daughter of abuse & wanting her home & money. Per daughter & notes, daughter stating her mother is demented. There are several interested parties - ROI is being requested. SW perspective - pt is vulnerable elderly woman - she wants to return home & would like her daughter Rita to leave the home, with a nurse to visit, (Accent Care) and hired help (also accent care) several hours a week - the pt is stating she

3INTER

350-8752-1143 (Rev. 8/02) HAB (PBS) FACE

Scripps Health | CASE MANAGEMENT SUMMARY REPORT | Page: 3
Facility: Encinitas | Print : 08/19/15 12:55
RIVES, Bobbye J | Acct#: 102074264 | REPORT ID: ZFLW001S-AGG10
MRN#: 200251338 | Attending MD: Dabestani, Ardeshir A
DOB: 10/23/1927 | Admit Date: 09/01/2014
Age:87 Sex: F | Disch: 09/06/2014

Finding	Service Date/Time	Result	Charted Date/Time	Charted By
Case Management Interval Notes.	09/06/14 12:44			
CM Interval Notes.				
Case Manager Interval Notes		Y	09/06/14 12:48	2-109453, PCN

9/6/14 @ 1230-Called and spoke with Pt. Nephew-Ralph to discuss DC for today. Confirmed that Ralph will be here around 3pm to drive Pt. to LVDC SNF. Confirmed that no pt. info given to anyone besides him today although we have received calls from various females (Rosalyn, Dr.Jones, Dr. Baxter-Jones, Jeanette). SW-Mark aware of pt. transfer to LVDC today & informed APS dept. for follow-up. DMSLayton, RN

9/2/14 11:26
MSW OCEANA GAGE OFFERING INFO AS OPTION FOR PROTECTION AND PT AND RALPH AGREE

AUDIT LEGEND

A - Added
U - Updated
D - Deleted

LEGEND of User Numbers

1	111215	Rabara, Lerida A PCN
2	109453	Slayton, Diane M PCN

SERVICE Index

Task

UPDATE NOTE

Task

Subject	UPDATE NOTE
Case Note Type	Update Note

MDT with Kathleen Welinsky, ST clinician involved with Clt. at this time. She stated that Clt. denied any wrongdoing by SA. Clt. manages all funds independently and is able to make decisions regarding her funds. ST CM stated that there is a long history of dis-functionality between the SA and the Clt. and in fact the Clt. has a history of hitting the SA if incensed.

Regarding	Case for Bobbye Rives on Feb 2 2011		
Owner	Shefali Dua		
Duration		**Priority**	Normal
Actual Start	2/9/2011		
Due	2/9/2011 4:00 AM		

Legacy Fields

Legacy ID	1,297,167	**Last Modified On**	2/15/2011
Legacy Client ID	154,190	**Last Modified By**	
		Last Modified By ID	cmorale1

Notes

6D

Appointment

In person contact

Appointment

Subject	In person contact
Location	
Regarding	APS Case for Bobbye Rives referred 7/23/2014

Scheduling Information

Required	Bobbye Rives		
Optional			
Start Time	8/12/2014 8:00 AM	**Duration**	1 hour
End Time	8/12/2014 9:00 AM	**All Day Event**	No
Show Time As	Completed	**Priority**	Normal
Case Note Type	Client In Person Contact		

APSS met with the CT at her home. APSS and CT discussed that the TRO was served. CT still wants to go to the Restraining Order hearing to obtain the Permanent Restraining Order. CT wants APSS to be present. APSS agreed to meet the CT at the court Friday morning. APSS and CT discussed her need for a caregiver. CT feels she can manage at home for right now, but may decide she wants a caregiver to come for one hour a day M-F. CT says her cousin is coming over this weekend and she has a caregiver, so she will discuss it with her cousin. CT said she did not like LivHome because she was unclear about the cost. APSS explained how billing from a care giving agency would work. CT was more open to hiring a caregiver. Please note, the CT's home is clean, the CT had good hygiene and appearance, and the CT has been cooking for herself safely. CT explained she does not want to be a burden on her nephew, so she may end up hiring a caregiver sooner then later.

Notes

Details

Owner	Karen Dee	**Organizer**	Karen Dee
Category		**Sub-Category**	

6D